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“They’re the hardest group to treat, that changes the least.”

**Adapted sex offender treatment programmes for individuals with autism
spectrum disorders: clinician views and experiences.**

First Author and Correspondence: Dr. Clare L Melvin, The University of East Anglia, Norwich, UK; The Tizard Centre, University of Kent, Kent, UK; The Broadland Clinic Forensic Service, Hertfordshire Partnership University NHS Foundation Trust, Norfolk, UK.

C.Melvin@uea.ac.uk

Second Author: Professor Peter E. Langdon, Centre for Educational Development, Appraisal and Research (CEDAR), Faculty of Social Sciences, University of Warwick, Warwick, UK.

Peter.Langdon@warwick.ac.uk

Third Author: Professor Glynis H. Murphy, Tizard Centre, University of Kent, Kent, UK.

G.H.Murphy@kent.ac.uk

ABSTRACT

Aims: Clinicians working with individuals with autism spectrum disorders (ASD) who display sexual offending behaviours may face challenges during treatment, as a result of the cognitive and behavioural profile associated with ASD. This research explored the views and experiences of those running adapted sex offender treatment groups with men with ASD.

Method: Semi-structured interviews with group facilitators (n=12) focused on service user engagement and response to the core components of the treatment programme (e.g. increasing victim empathy, addressing cognitive distortions, etc.), and gathered the experiences of those working with men with ASD who display sexual offending behaviours.

Results: Grounded Theory was used to develop a model conceptualising the potential impact of ASD on treatment outcomes, and this emerged predominantly through clinician's views of risk of re-offending. Benefits of attending a group included: the presence of other group members, a forum to develop pro-social roles and relationships, and increased opportunity for monitoring. Challenges regarding empathy, specifically emotional empathy, and shifts in cognitive distortions were felt particularly pertinent to those with ASD, as well as questions over internalisation of therapy.

Conclusion: Despite identification of a number of challenges, adapted sex offender treatment programmes were considered beneficial for men with ASD, especially in light of a dearth of evidenced-based alternatives.

INTRODUCTION

The proposed proclivity for criminal behaviours suggested in the early literature on Autism Spectrum Disorders (ASD) has not been confirmed (e.g. King & Murphy, 2014; Hippler et al., 2010, Mouridsen et al., 2008, Mouridsen, 2012), but nevertheless a small percentage of individuals with ASD, both with and without co-morbid ID, do commit offences (e.g. Lindsay et al., 2014; Kumar et al., 2017). As such, the call for evidence-based practice, coupled with a drive towards social inclusion and choice in care and treatment, has created challenges for those managing and treating offenders with ASD.

Crimes of a sexual nature remain prominent within offending research in ASD: e.g. nine of fourteen studies (64.2%) in a systematic review of treatment for offenders with ASD made reference to sexual offences and/or behaviours (Melvin et al., 2017), and within a forensic inpatient sample, 40.5% (n=17) of individuals with ASD, were reported to have a history of sexual aggression, compared to 26% (n=25), with such a history for those without ASD (Esan et al., 2015).

Group cognitive behavioural therapy (CBT) has been considered best practice in sexual offending treatment for some years (Marshall et al., 2003; Lösel & Schmucker, 2005), with programmes available for individuals with intellectual and developmental disabilities (IDD) and those without. These programmes are typically modular, delivered in a group over 6-12 months with content including: sex and relationships education, addressing cognitive distortions and offence-conducive attitudes, increasing victim empathy and development of a relapse prevention plan (SOTSEC-ID, 2010; Ward & Marshall, 2004).

Such programmes are utilised in mental health and forensic settings, community and secure services, as well as in prisons and probation services (Marshall, 1996; Lindsay et al., 1998; Rose et al., 2002). In neurotypical populations, sexual recidivism rates are typically placed between 10 and 15% after 15 years, with those failing to complete treatment at a higher risk of recidivism than those who complete treatment (Hanson & Bussiere, 1993). However, there have been some suggestions that treatment is not effective (Schmucker & Lösel, 2008; Mews, Di Bella & Purver, 2017), but these discrepancies are suggested to be the result of methodological issues or difficulties in attaining 'quality' research, particularly randomised control trials and identifying appropriate comparison populations, rather than the efficacy

of the treatment itself (Dennis et al., 2012; Duggan and Dennis, 2014). A comparable picture is reported in intellectual disability populations (often including those with ASD e.g. SOTSEC-ID, 2010), with sexual recidivism rates reported between 0 and 37.5% following treatment¹ (Jones & Chaplin, 2017), and some debate over whether higher offending and re-offending rates are found in sexual offenders with IDD than those without (Craig, Browne & Beech., 2008; Lindsay et al, 2006). Again, however, this evidence base is lacking in controlled and randomised research (Ashman & Duggan, 2008; Jones & Chaplin, 2017).

Despite the wide use of CBT programmes, there is little empirical evidence regarding their use for sexual offenders with ASD (with and without a co-morbid intellectual disability), with some studies suggesting poorer treatment outcomes associated with the diagnosis. For instance, data following sexual offenders with IDD over some years indicated that men with ASD displayed recidivist behaviours at a higher rate, predominantly non-contact sexual offences, in comparison to men with intellectual disabilities alone (Heaton & Murphy, 2013; Murphy et al., 2007; SOTSEC-ID 2010). Case reports by Kohn et al. (1998) and Milton et al. (2002) on two autistic individuals without an associated intellectual disability illustrated various treatment approaches having ‘little or no effect’, including individual and group CBT approaches. Nevertheless, some authors have reported an absence of recidivism (Kelbrick & Radley, 2013), reduced severity and frequency of sexual behaviours following treatment (e.g. Griffin-Shelley, 2010) or other implicit benefits such as improvements in social skills, employment and insight into risk (Melvin et al., 2019) both in individuals with ASD and an intellectual disability, and those without.

Clinical and theoretical conjecture has proposed that the cognitive and behavioural profile of ASD may create challenges to achieving positive treatment outcomes. For example social interaction and communication difficulties, cognitive rigidity (including special interests), social naivety, weak central coherence and deficits in empathy, in addition to sexual deviance and/or anti-social behaviour, have been hypothesised to result in low responsiveness to shifting anti-social attitudes and thinking patterns, or increasing empathy (Dein & Woodbury-Smith, 2010; Higgs & Carter, 2015; Murphy, 2010).

¹ Follow up periods ranging from 0 months to over 5 years.

Empathy deficits are a key issue regarding the possible impact of ASD on treatment outcomes for sexual offenders. Murrie et al. (2002) highlights six case histories of individuals with Asperger's Syndrome who displayed aggression. Four of these cases included sexual aggression with Murrie et al. reporting that these individuals appeared "*genuinely unaware of the harm they caused their victims*" (page 66).

Autism has been described as a disorder of empathy, with difficulties in identifying and responding to others' emotional states considered a dominant feature (Baron-Cohen, 2009; Frith, 2004; Tantam, 2012; Wing, 1981). The ability to distinguish between self and other, interpret the intentions of others and recognise emotional states, is essential in order to develop and display empathic behaviours. In relation to offending, victim empathy is believed to be present if an offender displays an appropriate emotional response to the experience undergone by his/her victim. This description incorporates two aspects of empathy: the ability to take the perspective of the victim, be 'in their shoes', and an emotional reaction (vicarious affective response). These aspects are referred to as cognitive empathy and affective empathy (Bird & Viding, 2014; Decety & Ickes, 2011; Hoffman, 2001; de Vignemont & Singer 2006), with current treatment programmes attempting to address both through psychoeducation and mentalisation-based exercises (Mann and Barnett, 2013).

There is scant information regarding treatment response in terms of cognitive and affective empathy in individuals with ASD, however individuals with ASD have a distinct empathy profile and differ from other clinical populations (both forensic and non-forensic samples) such as those with conduct disorder and callous-emotional traits (Schwenck et al., 2012; Jones et al., 2010). For example, Schwenck et al. (2012) found adolescents with ASD to showed better emotional empathy abilities than adolescents with conduct disorder (with and without callous-unemotional traits), however those with ASD demonstrated difficulties with cognitive perspective taking and emotion recognition.

With empathy deficits suggested in sexual offenders without ASD (e.g. Blake & Gannon, 2008; Ward et al., 2000), a potential cumulative effective of empathy deficits in offenders with ASD, is possible and may result in poor response to treatment or increased risk of recidivism.

In addition, addressing cognitive distortions is a key element of treatment with the therapeutic aim to 'shift' thinking patterns that reinforce or perpetuate sexual offending behaviours. Similarly to non-autistic sexual offenders, cognitive distortions have been identified within sexual offenders with ASD (e.g. Milton et al., 2002; Murphy, 2010). So far, it has not been possible to establish the aetiology of cognitive distortions, i.e. how and when they develop, yet they are recognised as playing a maintaining role within the sexual offending cycle (e.g. Wolf, 1984).

Difficulties in treating these 'faulty thinking styles' in offenders with ASD may be augmented by executive functioning deficits in ASD (Demetriou et al., 2018; Pellicano, 2012), impacting on cognitive inflexibility, including limited perspective taking abilities and/or increased egocentricity. Additionally, the assimilation of new information and application or transference of existing information to novel contexts may be reduced by weak central coherence often reported in ASD (Pellicano, 2010), and compounding the maintenance of cognitive distortions and impacting on treatment response in autistic sexual offenders.

Finally, rigidity and atypical cognitive processing has been implicated in sexual offending in autism in regards to special interests or obsessions, with a number of case studies making reference to repetitive or restrictive patterns of behaviours. These include physical manifestations such as excessive masturbation or paraphilia, as well as thought perseveration around deviant fantasies with little change following treatment (Barry-Walsh & Mullen, 2004; Milton et al., 2002).

The evidence base concerning the use of adapted sex offender treatment programmes for individuals with ASD currently consists of a small body of theoretical literature regarding the potential impact of ASD on sexual offender treatment outcomes (e.g. Dein & Woodbury-Smith, 2010; Higgs & Carter, 2015), along with a collection of case studies i.e. (Kohn et al., 1998; Murphy, 2010). Many of the authors of case studies identified in Melvin's et al. (2017) systematic review stated their opinions regarding treatment effectiveness for the individual with ASD, however it was not always clear as to the foundation of those views e.g. what was based on the author/therapist's interaction with the client and what stemmed from historical notes or records. Furthermore whilst recidivism and re-offending rates are typically the primary measure of effectiveness of sexual offending treatment, implicit

benefits or secondary outcomes which can provide information on treatment facilitation and perceptions of effectiveness and appropriateness of available programmes, went unmentioned due to the focus on further offending behaviours.

Aims of the Study:

This study was designed to address gaps in the literature regarding the appropriateness and effect of current treatment for autistic sex offenders. In particular, the principal research objective was to explore the use of adapted sex offender treatment groups for individuals with ASD by seeking clinician experiences and views of the effectiveness and appropriateness of such programmes. A related study exploring autistic service user experiences and views of adapted sex offender treatment programmes has also been completed (Melvin et al., 2019). In gathering clinicians' views the study also sought to consider if the features of ASD appear to be a vulnerability to effective participation within treatment programmes consistent with propositions in the current literature regarding the potential impact of ASD on treatment outcomes.

METHOD

Participants:

Ten clinicians were recruited for semi-structured interviews, conducted by the primary author. The clinicians were facilitators of adapted sex offender treatment groups and recruited from community learning (intellectual) disability teams and secure mental health services that had participated in a related study exploring autistic service user experiences of adapted sex offender treatment programmes (Melvin et al., 2019). In Melvin et al. (2019), thirteen men with ASD who had completed an adapted sex offender treatment group were interviewed to investigate their experiences of attending groups and to collate their views/perceptions of the benefits of such treatment programmes.

Following the recruitment of the service users for Melvin et al. (2019), ten group facilitators were recruited for the current study, with two facilitators having worked with more than one service user and therefore able to complete multiple interviews where other facilitators were unavailable. Group facilitators were approached for participation to ensure the

individual possessed an understanding of the treatment aims and objectives and thus was able to comment how well these have been achieved for a service user from Melvin et al., 2019.

As such, eligible clinicians within the current study were required to: (a) be familiar with an autistic service user from Melvin et al. (2019), and (b) have experience of sex offender treatment programmes for individuals with ASD. The gender and profession of the staff members were recorded along with the length of time they had worked with the participant with ASD and the type of service they worked in e.g. Community or Secure Service (as can be seen in Table 1). All clinicians worked in learning (intellectual) and developmental disability specific services, and all had run treatment groups often consisting of a mixture of men with ASD and ID, ASD alone or ID alone. Only one maintenance group (a monthly follow up group offered after the year-long sex offender treatment programme) had members with ASD (or ASD and ID) only². The demographics of the participants with ASD are discussed in Melvin et al. (2019) and were representative of other studies of offenders with intellectual and developmental disabilities, including histories of abuse, long involvement with services, prior anti-social behaviour and presence of other offending behaviours, as well as multiple psychiatric diagnoses (e.g. Lindsay et al., 2014, 2009; Langdon et al., 2013).

[Table 1 Here]

Design:

Purposeful sampling was utilised due to the specific niche of the target population and constraints relating to time and resources, but also to ensure that the sample was able to effectively take part in the interviews.

Procedure:

Ethics

The study received a favourable ethical opinion from the Bromley Research Ethics Committee (REC ref: 16/LO/0105) and staff were made aware that participation was

² This was not intentional but reflected the needs of the community and demand on services at that time.

voluntary, and the study was being carried out independently of their employer. All participants who wished to take part were asked to provide signed consent.

Interviews

The interview schedule was developed from previous qualitative research in adapted sex offender treatment programmes (e.g. Hays et al. 2007; Sinclair, 2011). As previous work had primarily focused on service user perspectives and treatment for those with intellectual disabilities, the schedule was refined in order to address facilitation and effect of treatment from a clinician perspective, as well as to explore potential issues specific to offenders with ASD, including those identified from the existing literature e.g. possible difficulties with the victim empathy components of treatment or the group delivery of the programme. The full interview schedule can be obtained from the primary author. Themes covered in the clinician semi-structured interview included: *How the individual with ASD engaged with the treatment programme? How the individual with ASD found taking part in a group? Whether they think the treatment has helped to reduce the risk of the individual with ASD displaying further sexually abusive behaviours? (e.g. any shift in cognitive distortions). Their experience of working with men with ASD who display harmful sexual behaviours and views regarding treatment e.g. if they feel the groups are appropriate, effective? How men with ASD compare to men with intellectual disabilities alone in treatment?*

Clinician interviews lasted approximately fifty minutes (M=52:16, SD=23:47) and took place in Community Learning Disability Team offices, residential home staff rooms and offices within secure mental health services.

Analysis:

Grounded theory (Glaser & Strauss, 1967, 2009; Strauss & Corbin, 1998; Charmaz, 2006) was used to analyse the interview data to allow for the structured analysis of qualitative data. As an interpretive method Grounded Theory moves beyond identification and description of themes or concepts and allows the analysis to develop new theory grounded in the data. This study was interested in the clinicians' experiences of facilitating treatment groups for men with ASD, however it was also concerned with exploring these experiences

in relation to hypotheses suggested in the literature regarding the potential impact of ASD on sexual offending treatment.

The analysis incorporated the approaches of Charmaz (2006, 2014) and Corbin & Strauss (2014). All interviews were transcribed by the primary author and read in full on multiple occasions. The transcripts were then coded using a 'line-by-line' system, followed by focused and theoretical coding to develop a model of how clinicians experience and assess the use of adapted sex offender treatment programmes for individuals with autism.

The coding process was accompanied by extensive memo writing and periods of free writing. Theoretical sampling was used to ensure focused exploration, refining of the categories and to ensure fidelity to the data collected. Techniques from Strauss and Corbin (2014) were also utilised to aid the process, including constant comparison (both within and between the transcripts) and the flipflop technique of rotating concepts to obtain a different perspective. The analysis and procedure were reviewed by the second and third authors on multiple occasions to ensure sufficient codes for saturation, and agreement was reached for all categories, concepts and the resulting model, along with key quotes representing each category.

RESULTS:

The analysis resulted in 477 identified codes which were refined into the Diagram (Figure 1) and Risk Formulation model displayed in Figure 2.

Clinician views and experiences regarding the use of adapted sex offender treatment programmes for individuals with ASD were characterised by opinions on appropriateness and perceptions of effectiveness. These two aspects were interlinked, with appropriateness (relevance, accessibility, etc.) of the treatment content and processes being associated with perceptions of successful facilitation of the group and subsequent 'effect' or positive outcomes.

Effectiveness was primarily conveyed by the clinicians in relation to judgements regarding an individual's risk of re-offending following treatment (Figure 1).

[Figure 1 Here]

Overview of Risk Formulation Model

From the questions asked to the clinicians regarding their experiences of facilitating adapted sex offender treatment programmes for autistic offenders **formulation of risk** (of re-offending) emerged as an overarching theme (Figure 2) that was grounded in four factors or subthemes regarding client presentation following sexual offending treatment. The subthemes were: (i) **treatment outcomes** (changes in empathy, sexual knowledge, cognitive distortions, etc., outcomes other than recidivism), (ii) **risk factors** e.g. anti-social attitudes and/or other criminogenic behaviours, poor mental health, limited support/social networks, etc. (iii) incidents of **recidivism**, and (iv) **protective factors** (such as employment, family and staff support, romantic or sexual relationships, and ‘keeping safe’ tools and management strategies, etc.). Although separate within the model, the treatment outcomes and risk factor subthemes were closely aligned.

Assessment of these themes was shaped by a diagnosis of an **autism spectrum disorder** (in relation to the individual, their offending and treatment) as well as wider, systemic issues regarding **treatment facilitation** (such as evidence-base, facilitator abilities and service provision). These informed clinical judgements regarding **responsivity to treatment** and subsequent risk formulation of re-offending.

Responsivity to treatment was constructed from views of the individual’s *attendance*, their *ability* to engage with the treatment, their level of *engagement* and any *internalisation* of therapy, as presented across the four subthemes.

[Figure 2 Here]

Autism Spectrum Disorders

Throughout the interviews, the clinical features of autism (e.g. social and communication difficulties, cognitive inflexibility and a deficient empathy profile) were referred to directly in the context of the treatment group. The possible impact of ASD symptomatology on psychosocial development, mental health and perception/assimilation of wider social influences was also discussed in relation to the development and maintenance of sexual offending behaviours.

The data contained numerous examples of the potential impact of ASD on **treatment outcomes, risk factors** and **recidivism** and how these shaped clinicians formulation of risk following treatment. These were expressed for the specific service user under discussion, and for those clinicians with more experience, in reference to individuals with ASD in treatment groups in general. Whilst some observations were made concerning rule adherence tendencies in ASD, there were few references to any **protective factors** associated with a diagnosis of autism throughout the interviews.

The *Social and communication difficulties* associated with ASD impacting on **treatment outcomes** were reported in accounts of group members who were unable to engage appropriately or integrate into the group, as well as in their difficulties interpreting social contexts and adhering to conventions:

Q1 - Marjorie³: "Well he just says sort of totally random things ... he'll go off on tangents and not really pick up what's happening, the mood of the room"

The misinterpretation of social contexts or violation of convention included an atypical motivation to attend the group and/or failure to recognise its purpose and acknowledge personal **risk factors** in some men. For example, two service users were identified as using the group to enlarge their social network, whilst another saw meetings as time with friends and not undergoing treatment with the specific objective to reduce risk of offending:

Q2 - Winston: "one of his goals that was set very early on in the early stages was to meet new people and make friends, so I think he saw a goal from this group was to enlarge his social networking rather than it be solving an issue around his inappropriate sexualised behaviour"

Additionally, the increased social engagement as a consequence of offending (through attendance at a treatment group or interaction with other agencies such as Probation services) was also noted as a possible form of positive reinforcement for one service user rather than a factor reducing risk of **recidivism**:

Q3 - Heejung: "... he likes going to probation because it's a 1:1 chat, ... a weekly meeting with probation, he enjoys that, it's not deterrent at all."

³ Clinicians real names have not been used

Wider social and cultural influences, including *internalisations of cultural depictions of masculinity*, were associated with social interaction difficulties which could impact **treatment outcomes**, possibly resulting in the persistence of some **risk factors**. Interaction difficulties identified in offenders with ASD included poor interpretation and negotiation of social and sexual scripts. For example, clinicians reported that service users made reference to their behaviours in the context of popular cultural figures such as James Bond and TV programmes illustrating promiscuous or debauched lifestyles. These fictitious or 'staged' depictions of relationships were interpreted, by some with ASD, as illustrative of 'real life', thus setting expectations for social encounters which then did not meet expectations:

Q4 - Aimee: "Those types of [TV shows] where it's all quite sexual and you don't see people asking for consent you see people drunk and having fun so he, attributes that to that's real life and he'll ask staff and assume that staff will go out and drink and have sex at the weekend ... he talks a lot about what sound like indecent assaults [he's committed prior to his index offence] so groping girls in clubs and he'd say, sometimes it works sometimes he got a kiss, sometimes he got a slap, but he's kind of saying, you know, 'it's worth it'."

As illustrated in the extract above, the service users also reflected certain social values, such as misogynistic or persecutory attitudes towards women, including a sense of entitlement to sexual gratification, which fell within the **risk factor** subtheme in clinicians' judgements of re-offending risk. Whilst these attitudes or assumptions are not specific to autistic sexual offenders, social naivety, information processing abilities, poor emotional regulation and communication difficulties may limit flexibility and assimilation of new information into a behavioural response when a social script deviates from expectation and increase risk of **recidivism**.

Difficulties with social interaction were frequently framed in relation to other aspects of ASD such as heightened ego-centricity, lack of victim empathy and cognitive distortions in conjunction with anti-social behaviours and/or satisfying criminogenic needs.

Cognitive inflexibility was illustrated in distorted thinking styles and perseverance around denial or blame, deviant fantasies, and in relation to issues of de-centralisation and theory of mind. Rigidity was described across multiple interviews in the context of persistently

reaching the same point in therapy, indicating limited **treatment outcomes** and minimal reduction in **risk factors**:

Q5 - Aimee: "... everyone's I think gone through the same cycle of no I really think I can help him and then, okay no, may not"

Q6 - Heather: "I don't feel that we are in a different place to what he was pre-the group, erm or indeed, pre-individual work, he did build on some of the ... but we're not in a different place"

An extreme example is given in the extract below, which refers to a service user who committed a sexual murder and illustrates the complex combination of ASD features, including rigidity in cognitive distortions, poor victim empathy, concrete thinking styles and low motivation to address deviant fantasies and how these interplay in the individual's risk and response to treatment:

Q7 - Heather: "We have consistently come to the same point where Henry (not his real name) will say, 'but I like these thoughts, I like these fantasies' and for him often his fantasy world is much more appealing his current situation, and so he actually doesn't want to change them ...we tried to a lot of work with the Good Lives and we were getting positive things to do in the community, but nothing seems to equate with the good feelings that these fantasies provide for him ... [The other group members] felt quite shocked at some of the things in his offence [during disclosure] and they'd asked him about his victim who was a father and they asked about the child, and they commented on [his] lack of emotion and I think they found that difficult to understand, but for Henry, he finds it difficult to understand how they think that way .. [in thinking] about the victim ... he will say, 'yeah I don't understand... I don't feel that feeling that the other patients are talking about'"

The above account is not an anomaly in the data and countless references were made to an *empathy profile* characterised by difficulties or deficits in victim empathy and perspective taking. These difficulties were portrayed in various ways, often seen as stemming from different causes, however victim empathy difficulties were reported across *all* clinician interviews.

Of the twelve interviews, only one clinician reported improvements in empathy in relation to increased feelings and understanding for his victim. This increase is believed to be linked to feelings of shame regarding the offender's behaviour and the negative social

consequence experienced e.g. the shame of losing his job and recognition of how unpleasant the situation would have been for his victim. Despite an apparent increase in empathy, this was not transferred across all situations, for whilst this individual was able to recognise and acknowledge the distress caused to his initial victim, distortions and denial around current 'potential' victims were still present, e.g. denial regarding harm to help line responders, when he was masturbating whilst talking, as the respondent *"isn't aware"*, demonstrating some limitation in the achievement of positive **treatment outcomes** and persistence of **risk factors**.

There appeared to be a general consensus amongst those interviewed that autistic sexual offenders can understand, to an extent, the cognitive aspects of empathy i.e. the concept of putting yourself in another person's shoes. The only reference regarding exceptions to this was in relation to offenders with more severe learning disabilities, or higher cognitive functioning but lower adaptive and social skills:

Q8 - Matthew: "Well I think the further you go down the severity of learning disability the less likely that the people are likely to be aware of other people's viewpoints so I think it gets worse the more severe you go down the cognitive functioning scale and perhaps, it also gets worse the more severe you go up the autism spectrum when the functioning is a bit higher, the more sort of Asperger's types of guys are really rigid in their thinking. And able to sort of argue against you a bit and kind of formulate their own viewpoints that are contrary to yours and yeah, so that's a whole new challenge in itself".

For the most part however, the service users in question were considered to have cognitive empathy but struggled with affective empathy and victim empathy.

As would perhaps be anticipated in descriptions of individuals that present challenges in achieving positive **treatment outcomes** regarding affective empathy, clinicians also made reference to poor emotion recognition and regulation. This included the ability of the service user to access and understand their own emotions, i.e. those that were present during their index offence (also see Q34 and Q35), as well as in the context of their future offending and recognition of emotional dysregulation as a possible **risk factor** that needed to be managed at times of increased stress or heightened arousal:

Q9 - Martin: "Also, they're [sexual offenders with ASD] the group that's most likely to struggle with identifying with their emotions, so it's quite hard for them to articulate the impact on others. Partly because it's hard for them to appreciate their own emotions around it, let alone other people's emotions in difficult situations."

When not constructed in relation to emotional processing difficulties or ASD associated egocentricity, victim empathy deficits were conveyed as a criminogenic trait and form of anti-social behaviour. This was a disregarding of others' feelings, rather than not knowing/understanding them, or showing empathy towards others (such as celebrities), but not their own victims:

Q10: - Sam: "That's not saying they're not able to empathise [sexual offenders with ASD]. They empathise with other people but not trying very hard to empathise with the victims."

Q11 - Heejung: "he was very, very disgusted that Rolf Harris was put in prison ... the consequences for Rolf Harris are obvious aren't they, he's gone to prison."

Although there are questions regarding the utility of increasing victim empathy as a deterrent against reoffending, many of the extracts identified illustrate its absence as a potential **risk factor** for the men with ASD.

Whilst a number of **protective factors** were identified by clinicians, these did not necessarily appear to be specific to individuals with a diagnosis of ASD or associated with its symptomatology. The only exception referred to was that, in comparison to individuals without ASD, anticipation of negative consequences for self, including family, was reported as a stronger deterrent than negative consequences for others (i.e. the victim). General social approval or desire to adhere to social rules and conventions was not recognised as a strong motivator for inhibiting reoffending behaviours in the sample.

Q12 - Martin: "I think the other thing that makes - prevents - him offending is he's lost one job for doing it. Haleem's (not his real name) got a part time job ... I think it does help him stay off of offending again. It's not wanting to lose his job, not wanting to lose the money, the shame of losing his job."

Q13 - Heather: "[he] thinks of the consequences for himself ... and can widen that out to his family who mean a lot to him ... but then taking it

that step further [to] think about the victim ... he will say '... I don't feel that feeling [empathy]'"

The continued and consistent contact with the men throughout the duration of treatment, and from any subsequent maintenance group, was highlighted by the clinicians as a protective factor. This was not only from the regular, direct communication with the group members, but also in liaison with the men's staff and support teams. This was reported as protective in that it facilitated the development of external management strategies (such as staff teams being able to utilise pro-active management approaches e.g. Q27), as well as the clinicians meeting the men on a regular basis and being able to notice any increase in risk:

Q14 - Aimee: "I think shift has been more around his ability to talk about these things which I think is really positive as we can start to get more of an insight into what is going on for him and look at strategies to manage it, but in terms of him being able to use the group to develop his own internal coping, I don't think he's managed that and he's very dependent, still on the external management"

Q15 - Martin: If they are re-offending, is [the group] reducing the frequency or intensity? ... I think so because of the indirect measures ... I think [the men with ASD] would find it easier to forget the consequences ... find it easier to start bring those distortions back without the group"

Interestingly, and perhaps controversially in terms of treatment implications, a number of the clinicians identified current or prospective romantic/sexual relationships as a **protective factor** against risk of re-offending:

Q16 - Heejung: "... and we think, well we know the protective factor for that is the fact that he's married and going to the brothel regularly, because if that relationship broke down, we would, could almost guarantee he would offend within a week."

Q17 - Frank: "I don't think any circumstances or anything had changed in him apart from, I suppose in terms of life circumstances his, personal life situation had changed since the time he committed the offence was that he got a girlfriend ... it was understood that they were having a sexual relationship so I think with that aspect that people felt that the risk was slightly reduced"

Multiple references were made by clinicians to service users' childhood and the potential impact upon their *psychosocial development*. The reported backgrounds were similar to

sexual offenders without ASD, with many from dysfunctional homes including multiple care placements and experiences of abuse or neglect, often being subject to family environments with pro-criminal or anti-social attitudes. As such, the possibility of maladaptive psychosexual development and inconsistent consequences (for the services users as a victim or an abuser), coupled with ASD, were identified as a potential **risk factor** for the development and continuation of sexual offending behaviours:

Q18 - Aimee: "I think there are some [empathy] deficits there, he's very much focused on meeting his own needs ... I think there are a number of issues there, part of which is his autism impacting on his ability to understand the other person's perspective ... but I also think there's his own sense of uncertainty about what's right and what's wrong ... because he was abused as a child and nothing happened to his perpetrator ... and he's never been convicted so there's no clear message in his life either as a victim or perpetrator that it's wrong"

Additionally, chaotic, absent or dysfunctional family relationships were likely to reduce the opportunity for pro-social support networks to act as a potential **protective factor** (as identified for some of the service users described in the sample e.g. Q13).

Poor *mental health* was recognised as a **risk factor** by the clinicians, with difficulties in emotion and information processing (potentially related to a diagnosis of ASD) considered to limit positive **treatment outcomes**. In particular, reference was made to the service users' poor understanding of the potential increase in risk at times of poor mental health:

Q19 - Heather: "I don't think he feels that he could be risky again, ... and he doesn't recognise that, when he was less supported in the community things got really difficult for him, so I'd say his insight, insight, understanding of those issues is limited still"

A re-occurring theme within the domain of *mental health* and *psychosocial development* was the impact of a co-morbid diagnosis of Personality Disorder (or a potentially differential diagnosis). One clinician reported that men with ASD were *"the group that's most likely to give accurate accounts, to be truthful"*. This refers to an accurate description of the event that happened (rather than interpretation of the interaction):

Q20 - Heejung: "it felt cold, you know quite graphic descriptions of what he'd done but presented in a very factual, cold way."

This kind of ‘honesty’ was also echoed by other clinicians and raised questions regarding anti-social personality traits as a **risk factor** and any potential impact on **treatment outcomes**. The similarities between ASD and psychopathy in this callous, unemotional or detached portrayal of their offences was recognised across the data, particularly for two services users where there were questions regarding the ASD diagnosis (as opposed to Personality Disorder). Personality Disorders, particularly those with traits of psychopathy, has been associated with poor treatment response and high risk of recidivism, as well as impact upon the staff and team ‘splitting’ (D’Silva, Duggan & McCarthy, 2004; Whittle, 1972). These aspects were observed in the data as illustrated in the extracts below.

Q21 – Heather: “I ..., if it’s more viewed as personality [disorder] or psychopathy, the staff will then often adopt this narrative, well there’s nothing we can do and how can we work with someone whose not even able to express empathy and emotion etc., etc., and then the work becomes much more difficult and it becomes then more focused on the staff team reflective practice ... we were formulating more in terms of autism but a couple of the facilitators were likening some of the traits to psychopathy in terms of feeling like he, not manipulates, but will do what he needs to do for people higher up in the MDT and say what he needs to say ...the discussions very much went around how much of this is autism and how much could be psychopathy?”

Treatment Facilitation

In addition to a **diagnosis of ASD**, the four subthemes contributing to clinicians’ risk formulations were shaped by wider, systemic elements that impacted the **facilitation of treatment**. These elements, or issues, moved beyond the individuals within the treatment groups, placing them within broader social structures, with clinicians identifying matters concerning the *content and process of available programmes (including the evidence-base)*, *facilitator abilities (including training)*, engagement with *other services/organisations*, and *service provision and resources*.

Clinicians often made reference to the lack of available *evidence-base* regarding sexual offending treatment for this population. As illustrated, clinicians commonly reported components of therapy where offenders with ASD appeared to struggle with the *content* more than those without ASD i.e. emotion recognition and the cognitive model, the victim

empathy module etc. (e.g. Q9), but emphasised the lack of available guidance or alternatives:

Q22 - Heejung: "...to compare it [adapted sex offender treatment groups] it to the alternative – I mean compared to what? Compared to no treatment? Absolutely!"

In relation to the group *process* of the sexual offending treatment programmes, clinicians emphasised the need for an individualised approach, with **a diagnosis of ASD** not being something that should automatically exclude an individual from engaging or being supported in group therapy:

Q23 - Matthew: "I've had guys (with ASD) go through that have benefitted, definitely but I wonder if that benefit could be just as powerful and even more powerful if the work was done on an individual basis and was adapted specifically to that person's specific behaviours and traits relative to autism. I think they can benefit from treatment definitely whether or not a group-based treatment is the most effective..."

Q24 - Majorie: "Well I felt that was the whole thing of the group last year... they were not that bothered about what we [facilitators] said ... but whenever some else [a group member] said it, it was always the thing that made the difference."

Q25 - Winston: "I think he's overcome that [social anxiety around groups] with a lot of normalising and sharing other people's worries."

Clinicians' perceptions of their own and other *facilitator abilities (including training)* were associated with familiarity and competency with the material, as well as risk formulation.

Reference was often made by clinicians to the overall ability of themselves and the team to effectively assess re-offending risk following treatment. As highlighted, some of this was connected specifically to a **diagnosis of ASD** and the complexities it can add to the formulation, especially if there was a co-morbid or suspected alternative personality disorder diagnosis:

Q26 - Martin: "... one pattern (in the team) is, almost like the dynamics which will happen with people with Personality Disorder - but not in terms of us necessarily being split, is switching from one alternative to the other side, being punitive and setting strong boundaries so when it comes to external controls, there's a tendency to say is that - the only thing that's

going to shift this person's behaviour is understanding the consequences. Sometimes that switches to us thinking - well hang on, we need to formulate more, we need to understand this a bit more."

Provision of external management strategies for offenders who struggle to control their impulses or lack the motivation to (perhaps indicating minimal positive **treatment outcomes**) were identified as reliant on liaison with *other services and organisations*. This included care and support staff, as well as the CJS, with comments regarding inter-agency working linked particularly to assessments concerning **risk factors, recidivism** and **protective factors**, during and following treatment in community services:

Q27 - Majorie: "... his staff team are very very good, it's very consistent, they know to distract him, and that makes a big big difference and they also communicate [with us] ... we've got other services that are not so good and those people continually re-offend or their placement breaks down so I think the fact he has a really good service does keep him protected. "

Q28 - Heejung: "I would like to see the court system back us up a bit more because if they haven't a treatment order, we can't make them come, and there are some people that desperately need to come, but because the court hasn't told them, they won't come and are continually re-offending out in the community."

Furthermore, clinicians reported supporting offenders 'out of Borough' due to lack of adapted treatment programmes in their home area:

Q29 - Heejung: "he's not actually in our borough anymore but we continue [permitting attendance to the maintenance group] because there isn't this type of group [in his] Borough".

Internal service provision and resources were also identified by the clinicians as impacting on judgements regarding risk of re-offending. For example, it was reported that one service user could benefit from repeating the SOSTEC-ID programme however this was dependent upon the current demand for treatment and comparative levels of risk:

Q30 - Sam: "it depends on referrals - who's judged more in need, more of a priority, more of a risk."

Responsivity to Treatment

The final component of the model, and contribution to the clinicians' formulation of risk of re-offending as illustrated in Figure 2, constituted judgements of **responsivity to treatment**. Responsivity was constructed throughout the interviews with reference to surface level engagement in terms of *attendance* at the group and the individual's *ability* to engage with the material. This then progressed to ability coupled with motivation resulting in *engagement* in the group. At this stage, motivation may not necessarily be focused on reducing sexual risk but, as discussed previously, for social benefits or being seen to be doing 'the right thing':

Q31 - Lola: "He chose to keep going, [he's] keen on doing his treatment and wanting to leave hospital so he's engaged but he doesn't really see himself as part of the [treatment] group".

The fourth step or level of responsivity was conveyed as *internalisation* of the therapy. This included references to perceptions of assimilation of new behaviours and management strategies into existing thoughts patterns and lifestyle choices, resulting in positive **treatment outcomes**, a reduction of **risk factors** associated with re-offending and/or an increase in **protective factors** against **recidivism**.

Q32 - Martin: "I think generally he's more empathic about victims.. not just [his] particularly victim, but hearing other men's accounts and the impact that's had on their victim."

The atypical *social communication and interaction* style and *empathy profile* reported in offenders with ASD appeared to make it more challenging to assess the extent of achievements in positive **treatment outcomes** and/or reduction in **risk factors**. This was reported by the clinicians in endeavouring to ascertain levels of treatment responsivity, particularly in relation to internalisation:

Q33 - Majorie: "You sometimes felt with the others [without ASD] that they 'clunked' into a better place where they really had taken it on board ... I didn't perhaps feel that with [the men with ASD], it wasn't quite possible to know whether or not they'd really internalised it."

Much of this difficulty appeared to be framed around clinicians' interpretation of emotional responsivity (or absence of) in the offenders with ASD:

Q34 - Martin: "Yeah almost like a dissociation which I hadn't felt in the others [without ASD] ... I mean everybody finds it hard [disclosing offence] ..., but there's a quality to the finding it hard that's slightly different [with offenders with ASD], ...So other people [without ASD] are either really traumatised about it and they don't want to say it because it's so awful or you they're really worried about it or they can't admit it at all, but you know these guys [with ASD], it's like the saying of the words but how, how connected are they?"

Interpretations of service user behaviour and mental state were complicated by clinician beliefs that the men with ASD struggled to understand their own behaviour or offence. Potential difficulties with insight, related to a diagnosis of ASD, affected opinion about how far the men were "*agents in their own behaviours*" and subsequently affected the clinicians' ability to assess any response to treatment and risk of re-offending:

Q35 - Martin: "Somehow, it feels like the formulation doesn't tell us enough about why the person does it (re-offend) ... we get a sense that they're not just telling us what we want to hear, but really puzzled themselves about what's going on about why they did something. ... Not understanding themselves in terms of offending cycle, not understanding their cognition. Sometimes, trying to piece that together afterwards feels like they're just trying to make a coherent account of what happened without it making sense at the time."

DISCUSSION

The interviews with clinicians regarding facilitation of adapted sex offender treatment groups for individuals with ASD showed consistency with propositions in the current literature on the potential impact of the clinical features of autism on treatment outcomes.

Themes emerged from the data that indicated clinicians felt social communication and interaction difficulties coupled with cognitive inflexibility impacted upon engagement and internalisation of key therapeutic aims, such as increasing victim empathy or shifting cognitive distortions regarding deviant fantasies or a sense of entitlement.

Additionally, atypical presentations of insight, emotion and perceptions of agency impacted upon the clinicians ability to formulate the offender's own understanding of their offence and subsequent responsivity to treatment, more so than in individuals with intellectual disabilities alone (e.g. Q9, Q33 and Q34)

Social naivety and the negotiating of social and sexual scripts has been proposed as a possible vulnerability to sexual offending in individuals with ASD (Woodbury Smith & Dein, 2014; Geluk et al., 2012, 2014), as well as this having been identified amongst self-reported motivations for sexual offending amongst autistic offenders (Payne et al., 2019).. There was some support for this illustrated in the clinicians' accounts, particularly in relation to expectations of relationships based on literal internalisations of cultural depictions of masculinity. With the exception of clinicians discussing autistic men with more severe intellectual disabilities, these difficulties were not always placed within the context of poor theory of mind or cognitive perspective taking but were more in line with heightened ego-centricity and a disregard or absence of consideration for the victim's feelings (affective empathy).

The clinicians interviewed in this study referred to an ability in the men with autism to say the right words and understand the premise of thinking from another's point of view (cognitive empathy). However the emotional resonance or affective response to the situation of another was noted as lacking (affective empathy) or did not appear to evoke empathic responding. Although not directly comparable due to being qualitative data, this finding is in contrast to other experimental studies which have measured higher levels of affective empathy in individuals with ASD than cognitive empathy, in comparison to individuals with psychopathy or callous un-emotional traits (Jones et al., 2010; Rogers et al. 2006; Schwenck et al. 2012). Although the empathy profile portrayed within the clinician accounts in this study was one of lower affective empathy (in comparison to group members with intellectual disabilities alone) it is not possible to ascertain how far the lack of concern for others is anti-social and a conscious violation of another's rights or, due to autistic difficulties with empathy as identified in the introduction (e.g. Baron-Cohen, 2009; Frith, 2004; Tantam, 2012, etc.) , or a combination of both.

The autistic sexual offenders discussed in the interviews by the clinicians were reported as showing similar patterns of distorting thinking to sexual offenders without ASD, including in their attitudes towards women (*women as sex objects, nature of harm and entitlement*) (Ward & Keenan, 1999; Polaschek & Ward, 2002), and a distinct lack of victim empathy. An overall deficiency of empathy in offenders with ASD was not often depicted by the clinicians, with examples of displays of empathy for other sexual offenders being given

(including peers and celebrities such as Rolf Harris or Gary Glitter). Some clinicians suggested this perhaps showed identification with the perpetrators point of view, as they themselves are perpetrators, rather than victims (although some of the men had themselves been victims of abuse). These reported discrepancies in displays of empathy (general compared to victim specific) are consistent with the debate concerning the status of perpetrator's thought patterns about their victims and whether they are a consequence of deficient empathy or a particular type of cognitive distortion (Fernandez et al., 1999; Marshall et al., 2001).

Thoughts of 'entitlement' (a recognised cognitive distortion in sexual offenders and one described in the clinician accounts) may not be ego-dystonic for offenders with ASD if their own pleasure is considered without reference to the other. Therefore, neither internal (delayed gratification) nor external factors (desire for social approval) evoke guilt, shame or empathic distress and lead to an empathic response, or inhibit sexual offending behaviours. As such, this may culminate in the illustrated lack of empathy and persistent thought patterns reported by the clinicians following completion of the adapted sex offender treatment programme (often multiple treatments).

For individuals with ASD, difficulties with theory of mind and challenges in considering 'other' rather than 'self', may contribute towards low victim empathy and culminate in action orientated towards meeting one's own needs without bearing in mind the experience of others. Additionally, difficulties with effortful control coupled with positive reinforcement (such as sexual gratification) and poor emotion recognition, as described by the clinicians interviewed, could result in a reduced capacity to orientate attention towards another, interpret socio-communicative behaviours e.g. facial expression and signs of distress, and inhibit a pleasurable, habitualised behaviour in order to activate a socially desired response (desistance from re-offending).

The challenges of working with individuals who display characteristics such as increased ego-centricity and low victim empathy were reported across the interviews. This was particularly pronounced in cases where there was question of a co-morbid or alternative diagnosis of personality disorder, with the subsequent impact on staff echoing findings of

other research in this area, e.g. splitting of the team, low expectations for therapeutic outcomes, etc. (Adshead & Jacob, 2009).

Clinical guidance from the National Institute of Clinical Excellence (NICE) emphasises the importance of addressing behaviour change, rather than underlying cognitions, in the therapeutic treatment for individuals with autism (NG142, 2012; NG170) (NICE, 2016, 2013). Descriptions of cognitive rigidity in sexual offenders with ASD from this study would further support such an approach, and perhaps call for a shift in therapeutic objectives when addressing criminal behaviours in individuals with ASD.

The views of clinicians reported in this study were only partially consistent with existing propositions that offenders with ASD struggle with group therapy (e.g. Higgs & Carter, 2015; Murphy, 2010). For example, within the interviews there were reported experiences that some men with ASD were unable to ingratiate themselves within the group, or were unperturbed by the viewpoints/challenges of peers. However, overall the clinicians' experiences and opinions varied and themes emerged in which the treatment group was constructed as a way of managing risk, with examples of positive outcomes that have not been so forthcoming across other literature on sexual offenders with ASD.

For example, positive outcomes reported in the study included increased opportunities for monitoring and responding to behaviours, along with the opportunities for the men with ASD to develop prosocial roles, skills and relationships. References to external management strategies and a focus on negative consequences for the offender by the clinicians identified these aspects as key deterrents of further offending behaviours, which is in line with existing research of offenders with ASD (Higgs & Carter, 2015; Dein & Woodbury-Smith, 2014; Melvin et al., 2017).

Strengths and Limitations:

Despite the study sample being small, it was fairly heterogeneous and included roughly equal numbers of clinicians from community services and those working in the secure estate. Clinicians were primarily psychologists, however the majority of those interviewed had extensive knowledge/a long working relationship with the service user in discussion

(range: 1-10+ years) and all were group facilitators enabling them to comment on the treatment components at a theoretical level (having undergone training), as well report on the service user's engagement/response to the material.

By interviewing clinicians about multiple service users from each site the study was able to gather opinions regarding different individuals within the same treatment group, however the sites were few in number and the majority were NHS (5 out of 6). The views of those working within independent healthcare services or charities were underrepresented, and clinicians providing services within the prison system or non-learning disabilities teams were not included in this study and as such this is an area for future investigation.

A point of note, and limitation to the data, is that many of the clinicians had run multiple interventions, including individual and group therapies for non-sexual or non-offending behaviours and thus any changes reported are likely to have been influenced by that as well as a consequence of the adapted sex offender treatment programme. Furthermore, the 'therapist-effect' is a well-recognised phenomenon suggesting that some variation in treatment outcomes is related to the therapist (Beutler et al., 2004; Wampold and Brown, 2005). This variance can include: therapist experience, use of a manual, length of treatment and type of treatment (Crits-Christoph et al., 1991) in addition to personal characteristics (Anderson et. al., 2016). As such, this may render those interviewed reluctant to emphasise a lack of positive treatment outcomes due to any potential implications regarding their skills and competencies.

Conclusions:

Within this study clinician views regarding the effect and appropriateness of adapted sexual offender treatment programmes for those with ASD were defined in terms of how these concepts were characterised. For example, some of the treatment components were considered inappropriate and/or ineffective, primarily those addressing victim empathy and shifting cognitions around perceptions of anti-social behaviour. The poor responsivity in these areas fed into a general belief regarding lack of internalisation of the therapeutic aims and thus little, if any, reduction of risk. The complexities around resistance to therapeutic aims referred to anti-social tendencies and well as difficulties in social interaction and cognitive functioning. For example, how far can internalisation occur if an individual has

difficulty with their own sense of agency and understanding of the behaviour, including processing of information at the time and the potential difficulties of autoneotic memory (temporal memory for self) seen in individuals with ASD (Boucher & Bowler, 2008). The limited benefits of repeating the treatment programme with offenders with ASD identified, also raises questions regarding conscious control over mental inflexibility in addition to motivation to change.

Despite these challenges, benefits of adapted sex offender treatment groups for men with autism were identified by those interviewed, including the opportunity to develop pro-social skills and roles within a group setting. Additionally, the potential for increased monitoring and liaison with other agencies was recognised by those interviewed as being able to enhance external management strategies and supplement any internal (offender-motivated) treatment gains to further reduce risk of re-offending.

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Table 1: Clinician Demographics.

Staff Pseudonym	Position	Service	Gender	Length of time worked with participant ⁴	Group Facilitator (Y/N)	Facilitated original treatment group or maintenance/ follow up work?
Heejung	Challenging Behaviour Specialist (Psychology Team)	Community ID service	Female	10+ years	Y	Both
Heejung ⁵	Challenging Behaviour Specialist (Psychology Team)	Community ID service	Female	10+ years	Y	Both
Frank	Specialist Practitioner in ID (Nursing Team)	Community ID service	Male	Missing	Y	Both
Martin	Consultant Clinical Psychologist	Community ID service	Male	10+ years	Y	Both
Lola	Trainee Forensic Psychologist	Specialist ID Medium and Low Secure Service	Female	2+ years	Y	Maintenance Group
Heather	Clinical Psychologist	Specialist ID Medium and Low Secure Service	Female	1.5 years	Y	Treatment Group
Aimee	Trainee Forensic Psychologist	Specialist ID Medium and Low Secure Service	Female	2+ years	Y	Maintenance Group
Aimee ⁶	Trainee Forensic Psychologist	Specialist ID Medium and Low Secure Service	Female	2+ years	Y	Maintenance Group and 1:1 sessions

⁴ Service users with ASD in Melvin et al., 2019.

⁵ Participant completed interviews for two different service users.

⁶ Participant completed interviews for two different service users.

Majorie	Clinical Psychologist	Community ID service	Female	1.5 years	Y	Both
Winston	Learning Disability Nurse	Community ID service	Male	2.5 years	Y	Both
Sam	Psychiatrist	Community ID service	Male	3-4 years	Y	Treatment Group
Matthew	Forensic Psychologist	Specialist ID Medium and Low Secure Service	Male	10+ years	Y	Treatment Group

Figure 1: Clinician views and experiences of adapted sex offender treatment programmes with individuals with ASD.

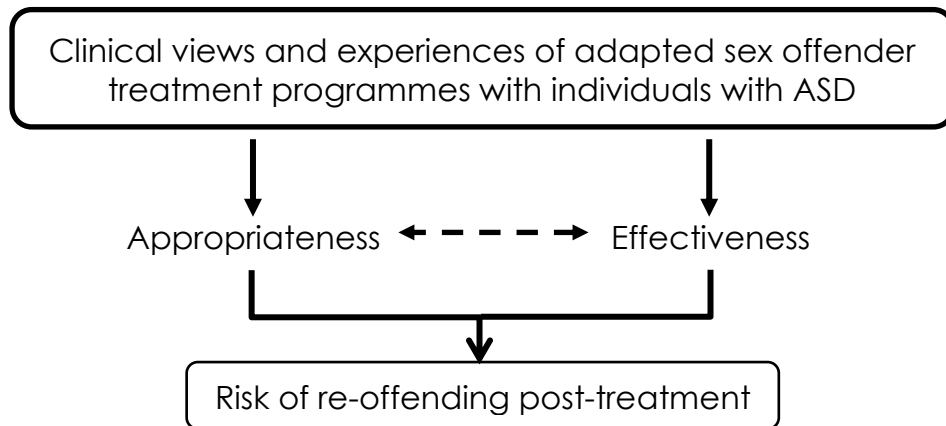


Figure 2: Formulation of Risk Following Treatment

